ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
9535 E. DOUBLETREE RANCH ROAD, SUITE 100, SCOTTSDALE, AZ 85258
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Nov. 14, 2017 Case Number: 18-35

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Kenneth Halbach (license # 0850)
Premise Name: Buena Pet Clinic
Premise Address: 900 N. Swan Rd
City: Tucson State: AZ Zip Code: 85711
Telephone: (520) 323.9487

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Tiffany C. Jennings
Address: [redacted]
City: [redacted] State: [redacted] Zip Code: [redacted]
Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

RECEIVED
NOV 14 2017
BY:

C. PATIENT INFORMATION (1):

Name: Sweetpea

Breed/Species: Chihuahua

Age: 13 Sex: F Color: Fawn

PATIENT INFORMATION (2):

Name: N/A

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Pancreatitis: Alta Vista Vet Hospital (602) 277-1464
(have records if needed) 4706 N. 7th Ave Phoenix, AZ 85013

Dental cleaning: Buena Pet Clinic (520) 323.9487
900 N Swan Rd. Tucson, AZ 85711

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Brad White [redacted]

Lorien Nelson [redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: [signature]

Date: 07 Nov. 2017

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Please see all attached documents:

Enclosed:

1. Statement from Tiffany C. Jennings
2. Statement from Lorien Nelson
3. Statement from Brad White
4. Letter from Dr. Gene Nightengale
5. Sweetpea's vet records (2004 - 2017)
6. AZ State Vet Medical Exam Board Case # 09-100

Tiffany C. Jennings, MPH
[redacted]

07 November 2017

To The Arizona State Veterinary Medical Exam Board (c/o Investigating Board):

On Monday, 09 October 2017, I visited Buena Pet Clinic (900 N. Swan Rd Tucson, AZ 85711) with my 13-year-old Chihuahua, Sweetpea. The purpose of the visit was for a potential infection in her right eye and to request a full blood panel for her records as a preventative approach to her care due to her age. Additionally, I requested an estimate for a routine dental procedure for teeth cleaning. After the requests, Dr. Kenneth Halbach (License number 0850) stated the labs would also be reviewed to ensure that it was safe to perform the dental procedure under anesthesia.

On this day, Dr. Halbach treated Sweetpea and determined that she had conjunctivitis in her right eye and provided medication. We scheduled Sweetpea for a teeth cleaning on Friday, 13 October 2017. Dr. Halbach stated he would call with the lab results to confirm whether Sweetpea was healthy enough for dental treatment under anesthesia. Therefore, my understanding was that the procedure was contingent on the results of her labs.

Thursday afternoon, 12 October 2017 I had not heard from Buena Pet Clinic. I called to ask about the status of Sweetpea's labs. I was informed by the secretary that, "Dr. Halbach says her labs are perfect" and "it was okay to bring her in for the dental procedure the following day."

Friday, 13 October 2017, I dropped Sweetpea off at Buena Pet Clinic at approximately 0745. The tech who greeted Sweetpea and I in the waiting room noticed that IV Fluids (IVF) were not included on the estimate and indicated that IVF is recommended for older dogs. I was surprised by this and said that I thought it was standard practice to include IVF during any procedure requiring anesthesia and told the tech to include IVF regardless of cost. Additionally, I asked a second time if they were certain that her labs were okay for her to go under anesthesia. The tech went to speak with Dr. Halbach and when she returned, informed me that "Sweetpea's labs are impeccable." After signing documents, I handed Sweetpea over to the tech and left the office.

At 0827 the tech called me to confirm that they would add the IVF and indicated the additional fee – to which I agreed. At 0922, I received a call from the clinic and my heart immediately sank. It was Dr. Halbach delivering the terrible news that Sweetpea had passed away upon administering the anesthesia. I explained that I needed to hang up the phone so I could process what I was being told. Shortly after, a co-worker, Mrs. Lorien Nelson, drove me to the clinic. When Dr. Halbach entered the room, he explained that she stopped breathing and her heart stopped simultaneously and that they attempted resuscitating her with no positive outcome. Additionally, Dr. Halbach stated that, "sometimes this just happens – every couple of years it happens and there's no explanation." His demeanor was very cold, off-putting, and he lacked compassion. Additionally, we discussed what I would like to do with Sweetpea's remains.

Tiffany C. Jennings, MPH
[redacted]

On Thursday, 19 October 2017, I was notified by the clinic, via phone, that Sweetpea's ashes, paw print, and records were ready for picked up. Upon retrieving the items, I requested a meeting with Dr. Gene Nightengale (owner of Buena Pet Clinic). Additional requests were made, although these were refused on 01 November 2017 via email (enclosed).

Upon review of Sweetpea's records (2004 – 2017) and additional research, I am asking that an investigation be performed based on the following:

1. Lab results inaccurately communicated to owner
2. Pages 4 – 6 of Sweetpea's lab results (enclosed)
    a. Low creatinine
    b. High white blood cell count
    c. High neutrophil and neutrophil band
        i. Page 5 states: "neutrophils appear slightly toxic"
    d. High monocytes
    e. Very high Spec cPL
        i. Page 5 states: "Serum Spec cPL concentration is significantly increased which occurs with pancreatic inflammation. If clinical signs of pancreatitis are not present, consider additional diagnostics, instruct owner to monitor closely and recheck Spec cPL in 2 to 3 weeks. If clinical signs of pancreatitis are present, treat appropriately, investigate for risk of factors and concurrent diseases including gastroenteritis or foreign body. Monitor Spec cPL to help assess response to treatment"
3. Medication dosage and weight discrepancy:
    a. Weight:
        i. Weight in 2010 (for same dental procedure): 4 pounds, 6 ounces
        ii. Weight in 2017: 3 pounds 14 ounces
        iii. Half (1/2) pound discrepancy
    b. Dosages (despite weight discrepancy):
        i. 2010 procedure: PA-atropine 0.135 mg plus ace 0.10 mg
        ii. 2017 procedure: PA-atropine 0.135 mg (0.25 ml) plus ace 0.10/mL/mg
        iii. In both cases, anesthesia (isoflurane) was then administered via inhalation
4. Many documentation issues and discrepancies:
    a. 2017 procedure: PA-atropine 0.135 mg (0.25 ml) plus ace 0.10/mL/mg (incorrect annotation of dosage/not an actual dosage)
    b. 2010 and 2017 isoflurane anesthesia MAC Value (dosage rate) is not documented
    c. No indication of anesthesia risk assessment
    d. 2010 and 2017: Names of staff present for procedures and what roles each person played in the procedure not documented
    e. IV fluid rate not documented
    f. Huge dose discrepancy for epinephrine (0.03 – 0.3 via IV)
    g. Dosage measurement for epinephrine not documented

In addition to independent research, I sought the advice and medical expertise of an unrelated, and unbiased AZ State licensed veterinarian and a board certified human anesthesiologist and requested a review of Sweetpea's medical records from 2004 – 2017. Based on this, it's my understanding that:

1. Gaseous anesthesia is unreliable and current standard practice for veterinary medicine is Propofol
2. Medication combinations and dosages were too high for Sweetpea's weight and size, was unsafe for use:
    a. Biochemical pathways and physiological responses that result from the combination of medications used
        i. increased potassium levels
        ii. extreme arrhythmia
        iii. slowed respiration
    b. Combination induced simultaneous apnea and cardiac arrest (which is otherwise an abnormal response – one typically happens before the other)
3. IV Fluids are standard practice for all procedures with anesthesia – not just older animals
4. PA-atropine and ACE combo is an older drug combination (safer methods available)
5. Based on age alone, a recommendation for veterinary anesthesiologist and/or dental specialist should've been made (this was not offered)
6. Lab values were blatantly ignored and owner was misled

Based on the data provided, Sweetpea should not have received general anesthesia due to her weakened and stressed immune system based on her lab results. I trusted the advice of a supposed veterinary professional. Had I been informed of the lab results, I would not have allowed the procedure with anesthesia and would have treated Sweetpea for the pancreatitis, which I informed Dr. Halbach that she had a history of, and is recorded on page 3 of the records dated, 09 October 2017.

Moreover, I discovered that Dr. Halbach was found guilty by The Arizona State Veterinary Medical Examination Board in 2009/10 for regulatory violations (case #09-100 - enclosed) – a couple of which were "failure to interpret the animal's bloodwork results correctly" and improper documentation. The situation leading to case 09-100 resulted in the death of the animal.

The findings from case 09-100, Sweetpea's records, and the statement made by Dr. Halbach on the day of Sweetpea's death ("this just happens"), all indicate:

1. Gross incompetence
2. Gross negligence
3. Failure to maintain accurate records
4. Failure to provide accurate information to clients
5. Blasé approach to animal care and treatment
6. Inability to learn from past mistakes

All of which, has led to the untimely and avoidable deaths of, at a minimum, two very loved animals (the statistical odds of *only* two animals inexplicably dying under his care is very unlikely due to under reporting bias).

As a 60% Service Connected Veteran (30% is for anxiety due to time served in combat) the untimely and preventable death of Sweetpea has created an extreme emotional response. My full-time employment and personal life is negatively impacted through multiple work absences, missed assignments, loss of concentration, memory recollection, isolation, anxiety attacks, extreme guilt because I failed to protect her, sleep disruptions, migraines, shortness of breath, disruption of routines, overwhelming and often debilitating emotions, loss of purpose and identity, and hopelessness.

Although Sweetpea was not registered as a licensed therapy or emotional support animal, this is the type of assistance that she provided to me: reduced stress, relieving loneliness, increased activity, and unconditional love. Sweetpea was my sidekick – she went ***everywhere*** with me, which was never an issue given her tiny size. We traveled to 26 states together; she was the best travel companion and co-pilot and was incredibly well behaved, having earned the nickname "Game Changer" from large dog lovers because she reset people's prejudices for small dogs.

The magnitude of heartache and pain Dr. Halbach causes in the owners of these beloved animals can never go away, but justice can be served by ensuring that he is never able to kill another animal whose care he was mistakenly trusted with. In addition to Sweetpea's records, I beg the Board to consider reviewing all records of animals that have died under the care of Dr. Halbach. The cruelty and mistreatment of animals cannot continue through Dr. Halbach's malpractices. This level of unethical practice is unacceptable – he is a liability to, not only Buena Pet Clinic, but to the profession of Veterinary Sciences.

Respectfully,

Tiffany C. Jennings, MPH

Enclosed:
Letter from Mrs. Lorien Nelson
Letter from Mr. Brad White
Letter from Dr. Gene Nightengale
Sweetpea's Veterinary records from Buena Pet Clinic (2004 – 2017)
Arizona State Veterinary Medical Exam Board Case Number 09-100

LORIEN C. NELSON

November 3, 2017

Lorien C. Nelson
[redacted]

To Whom It May Concern:

I am writing to document observations on the day my friend and coworker, Tiffany Jennings, experienced the heartbreaking, sudden death of her dog, Sweetpea.

Around mid-morning, on Friday, October 13th, I received a call from Tiffany. She was in tears, and sounded like she was trembling and breathless. She told me she received a call and was informed her dog had died. I offered to drive her to the clinic, to see Sweetpea. She accepted, as she said, "I can barely stand."

On the drive to the Buena Pet Clinic, Tiffany shared some of her feelings and thoughts of devastation and shock. She told me she always imagined she would be with Sweetpea, comforting her, at the time of her passing. She indicated she didn't want to let her thoughts go to a place in which she immediately began questioning and/or blaming Sweetpea's death on the Veterinarian, Dr. Kenneth Halbach. However, she was concerned given how small Sweetpea was. She told me Dr. Halbach had ran additional tests on Sweetpea, prior to her procedure, and was reassured her labs looked great. In fact, she recalled how it was noted how good the labs looked, given her age. She noted the Buena Pet Clinic had cared for Sweetpea ever since she was a puppy. Tiffany called the clinic when we were en route, to inform the staff she was on her way, and wanted to see Sweetpea.

When we arrived at the clinic, Tiffany asked if I would accompany her to say her goodbyes. She was understandably overcome with grief, and I remember feeling angered they made her sit in the waiting room for 5-10 minutes. Since we had called when we were on our way, I had expected more preparation and consideration for her arrival. There were other people with dogs coming in and out of the waiting room during this time.

When Tiffany was called back to the exam room, Sweetpea had been laid on a folded towel, and covered, except for her face. Tiffany was able to spend time talking to Sweetpea, actively grieving, and saying her goodbyes, prior to Dr. Halbach entering the room. She indicated at some point, "I can't be here anymore," and I asked if she wanted

[redacted]

me to cover Sweetpea's face. She had to go to the back door of the exam room to find someone and let them know she was ready to talk to the vet so she could leave.

I was immediately put-off by Dr. Halbach (I had never met him before or been to this vet clinic). He stood in the doorway to the exam room, and continued unrelated conversations with staff in the back. He was dressed-down, in jeans and a casual shirt. His condolences to Tiffany, seemed to me, forced and hollow. I recall him putting his hand on Sweetpea at times when he was talking. Although I cannot recall all of the specific words and phrases he said; I do remember him saying, "sometimes this just happens," and "maybe we need to do a better job of warning people [before they consent to these procedures]," and "every few years," this occurs. He did not share many details at all, from my recollection, of the specific cause of Sweetpea's death, only that she "stopped breathing," and, "there are some things we do," in an effort to resuscitate Sweetpea. Tiffany indicated she wanted Sweetpea cremated, and asked about the container/urn she would receive the ashes in. Dr. Halbach entered the back area, with the door open, and, in my opinion, callously said something to a staff member, like, "she wants to see the [container]." My overall impression was that he was not very sensitive in his interaction, despite Tiffany's outward grief, and was lacking on technical details regarding what happened with Sweetpea's procedure.

My heart hurts for Tiffany, and the long road of grief she has ahead. Sweetpea was her partner, one of her very closest family members - and how the Buena Vet Clinic appears to have mishandled her procedure and death is adding a heavy layer of darkness during this mourning period. I sincerely hope, if the clinic and/or Dr. Halbach are found to be at fault in anyway in Sweetpea's death, steps will immediately be taken to ensure this never happens to another dog and family again.

Respectfully,

Lorien Nelson

Lorien C. Nelson

Buena Pet Clinic, LLC
900 North Swan Road
Tucson, Arizona 85711
(520) 323-9487

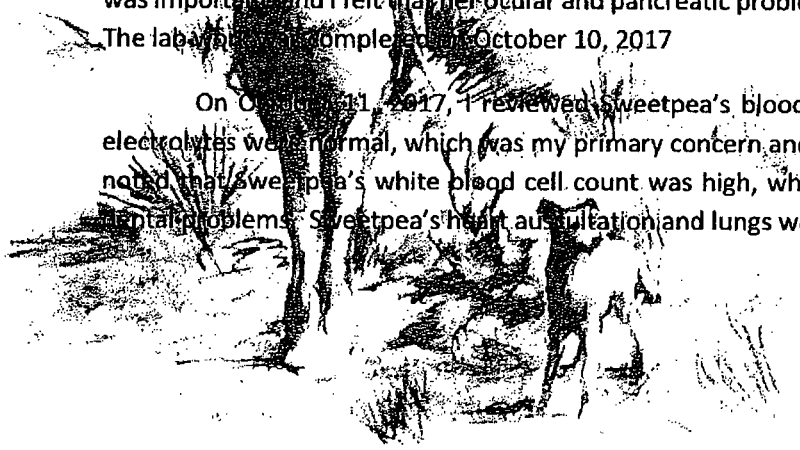
In Re: Kenneth Halbach, D.V.M., Cause No. 18-35

Sweetpea was a thirteen (13) year old female Chihuahua presented to Buena Pet Clinic on October 9, 2017. Sweetpea's owner, Tiffany Jennings, indicated that Sweetpea had greenish discharge in her right eye, had vision/depth perception problems, suffered from failing hearing, and a history of pancreatitis. During the visit, Ms. Jennings requested a dental cleaning estimate and requested renal tests for Sweetpea.

On October 9, 2017, I conducted a physical examination on Sweetpea, and noted that she had evidence of severe dental disease and conjunctivitis in her right eye. Overall, though, she was bright, alert and responsive to commands. Sweetpea appeared to be in good health. Given Sweetpea's age and her reported history of pancreatitis, I recommended that we obtain a blood panel before proceeding with a dental cleaning procedure. As noted in the medical records, I also prescribed Neopolydex ointment for Sweetpea's right eye. A copy of Sweetpea's medical records are enclosed herein. Since a portion of the medical records contain hand-written notes, I have included a typed version of the hand-written portions of the medical records.

I discussed the prophy procedure at length with Ms. Jennings. We went over the risks and benefits associated with general anesthesia versus the dental disease. I informed Ms. Jennings that proper dental hygiene is vital for a senior pet's health. I explained how dental disease can often lead to liver abscesses, heart valve abscesses, urinary tract infections, and other serious problems. We also discussed the increased risk of anesthesia complications for older dogs, and I explained that Sweetpea's age increased the potential for anesthesia complications. I also explained the importance of proper dental hygiene, and we discussed the prophy procedure in detail. After answering all of her questions, Ms. Jennings requested that we perform a full blood panel, and schedule a dental cleaning if determined appropriate. I agreed with Ms. Jennings' decision to proceed with the blood panel and prophy because Sweetpea's dental health was important, and I felt that her ocular and pancreatic problems could be related to her dental infection. The lab work was completed on October 10, 2017

On October 11, 2017, I reviewed Sweetpea's blood panel. Her hepatic, renal functions, and electrolytes were normal, which was my primary concern and important for the safe use of anesthesia. I noted that Sweetpea's white blood cell count was high, which was expected given the severity of her dental problems. Sweetpea's heart auscultation and lungs were also normal.



Buena Pet Clinic, LLC
900 North Swan Road
Tucson, Arizona 85711
(520) 323-9487

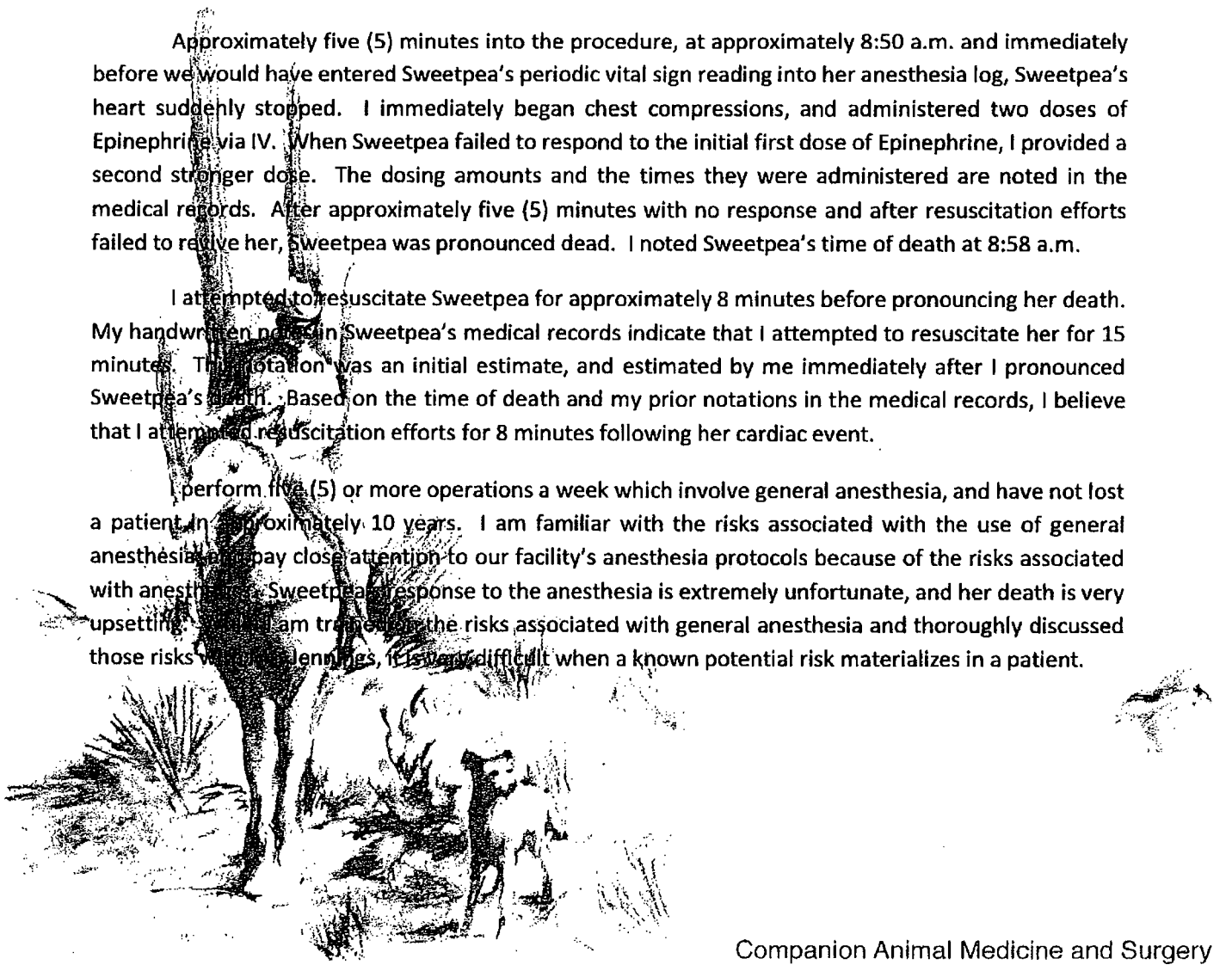
On October 13, 2017, Sweatpea presented to the facility for the dental cleaning procedure. I again reviewed her blood panel. I felt that Sweetpea's blood work was appropriate for a senior dog, and that her blood work made her a good candidate for anesthesia. Nevertheless, I requested authorization from Ms. Jennings to initiate an IV during the procedure to provide Sweetpea with additional fluids during the cleaning. Ms. Jennings approved the use of the IV fluids.

Sweetpea received pre-anesthetics approximately twenty (20) minutes before the procedure. An IV was placed in Sweetpea's left cephalic vein at 8:43 a.m. Sweetpea was provided Atropine 0.135mg and Acepromazine 0.1 mg subcutaneously, as per the dosing recommendations contained in Plum's Veterinary Drug Handbook. She was induced with 3% Isoflurane and Oxygen by mask. After induction, Sweetpea was maintained on 1 1/2% Isoflurane and Oxygen. Sweetpea initially tolerated the induction and anesthesia well. I observed normal readings and began the cleaning procedure.

Approximately five (5) minutes into the procedure, at approximately 8:50 a.m. and immediately before we would have entered Sweetpea's periodic vital sign reading into her anesthesia log, Sweetpea's heart suddenly stopped. I immediately began chest compressions, and administered two doses of Epinephrine via IV. When Sweetpea failed to respond to the initial first dose of Epinephrine, I provided a second stronger dose. The dosing amounts and the times they were administered are noted in the medical records. After approximately five (5) minutes with no response and after resuscitation efforts failed to revive her, Sweetpea was pronounced dead. I noted Sweetpea's time of death at 8:58 a.m.

I attempted to resuscitate Sweetpea for approximately 8 minutes before pronouncing her death. My handwritten notes in Sweetpea's medical records indicate that I attempted to resuscitate her for 15 minutes. This notation was an initial estimate, and estimated by me immediately after I pronounced Sweetpea's death. Based on the time of death and my prior notations in the medical records, I believe that I attempted resuscitation efforts for 8 minutes following her cardiac event.

I perform five (5) or more operations a week which involve general anesthesia, and have not lost a patient in approximately 10 years. I am familiar with the risks associated with the use of general anesthesia and pay close attention to our facility's anesthesia protocols because of the risks associated with anesthesia. Sweetpea's response to the anesthesia is extremely unfortunate, and her death is very upsetting. While I am trained on the risks associated with general anesthesia and thoroughly discussed those risks with Ms. Jennings, it is very difficult when a known potential risk materializes in a patient.



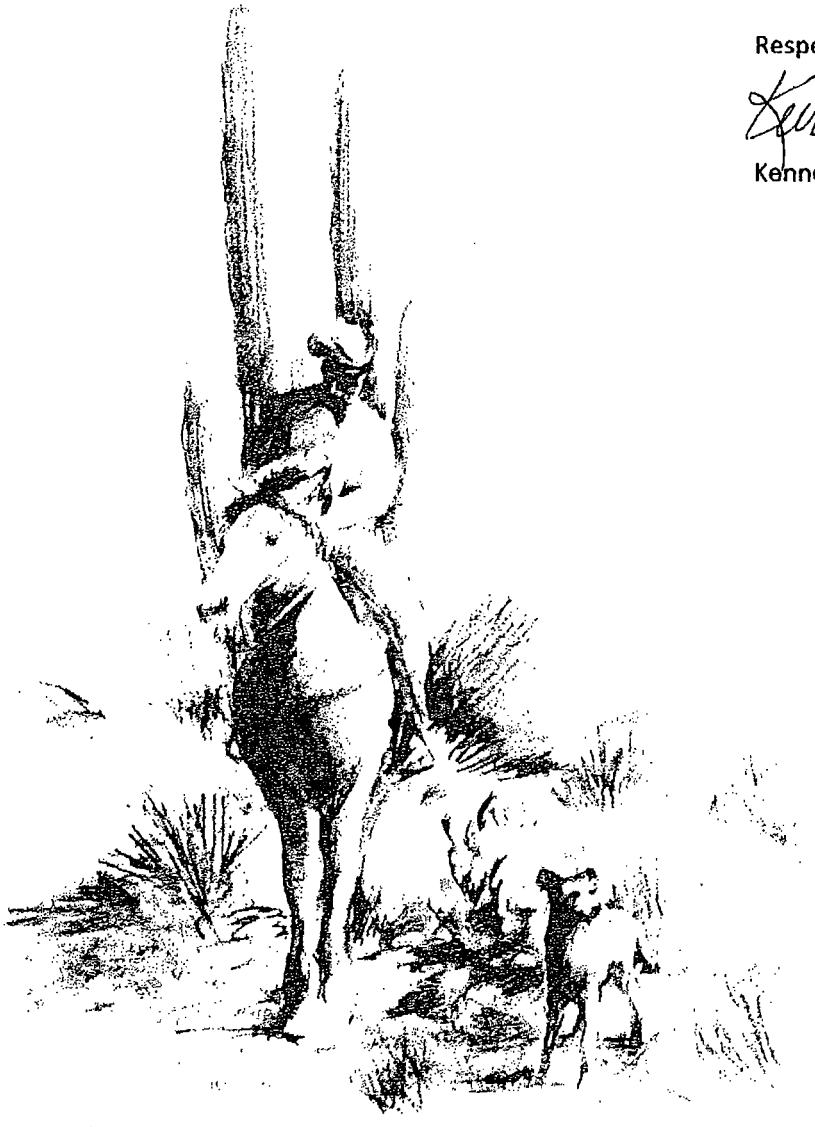
Buena Pet Clinic, LLC
900 North Swan Road
Tucson, Arizona 85711
(520) 323-9487

After Sweetpea's death, I met with Ms. Jennings to discuss the operation, Sweetpea's reaction to the anesthesia, and to make arrangements for Sweetpea's remains. I expressed my condolences and deep sympathy to Ms. Jennings. Given the extreme pain and grief associated with losing a pet, I understand how Ms. Jennings could have misinterpreted my feelings of sympathy for her. I regret that she could not find solace in our conversation following Sweetpea's death.

I am confident that all veterinary services provided to Sweetpea were performed professionally, and in compliance with the applicable standard of care. A copy of the Sweetpea's medical records, anesthesia record, and her blood panel are enclosed. I have also included a typed version of the hand-written portions of Sweetpea's medical records for your convenience. Thank you for providing me with the opportunity to respond to this Complaint. I respectfully request that the Board dismiss Claim No. 18-35 with no violations.

Respectfully submitted,

Kenneth Halbach, D.V.M.



DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1-PET (1738) • FAX (602) 364-1039
VETBOARD.AZ.GOV

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, D.V.M.
Donald Noah, D.V.M.
Christine Butkiewicz, D.V.M.
Tamara Murphy

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Sunita Krishna – Assistant Attorney General
Victoria Whitmore, Executive Director

RE: Case: 18-35
Complainant(s): Tiffany Jennings
Respondent(s): Kenneth Halbach, DVM (License: 0850)

SUMMARY:
Complaint Received at Board Office: 11/14/17
Committee Discussion: 2/6/18
Board IIR: 3/21/18

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow)

On October 13, 2017, "Sweetpea," a 13-year-old female Chihuahua was presented to Respondent for a dental cleaning. Blood work was performed the previous visit and Respondent felt the dog was healthy to undergo the anesthetic procedure. Shortly after induction, the dog arrested; resuscitation efforts were unsuccessful and the dog passed away.

Complainant contends Respondent was negligent in the care of the dog.

Complainant was noticed and appeared. Witness, Lorien Nelson, appeared.
Respondent was noticed and appeared.
The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Tiffany Jennings*
- Respondent(s) narrative/medical record: *Kenneth Halbach, DVM*
- Witness(es) narrative: *Lorien Nelson and Brad White.*

PROPOSED 'FINDINGS of FACT':

1. On October 9, 2017, the dog was presented to Respondent to have her right eye checked, blood work performed and an estimate for a dental procedure. Complainant reported that the dog had green mucousy discharge coming from the right eye. She further relayed that the dog had issues with pancreatitis in the past.

2. Upon exam the dog had a weight = 4 pounds, a temperature = 102.1 degrees, a pulse rate = 120bpm and a respiration rate = 32rpm. Respondent noted the dog had severe conjunctivitis to the right eye – Fluorescein stain showed no uptake. He also identified severe dental disease and discussed blood work prior to proceeding with a dental procedure, which was approved. According to Respondent, he went over the risks and benefits associated with general anesthesia verses dental disease explaining that dental disease can often lead to serious problems. Blood was collected, the dental was scheduled for October 13, 2017 and the dog was discharged with Neopolydex ointment for the right eye.

3. On October 10, 2017, blood results revealed the following abnormalities (Respondent submitted the wrong dog's blood work in his response – these values come from the blood work report submitted by Complainant):

Creat	*0.4*	*0.5 – 1.5*
WBC	*22.1*	*4.9 – 17.6*
Platelet	*483*	*143 – 448*
Neuts	*15558*	*2940 – 12670*
Band	*221*	*0 -170*
Mono	*2829*	*130 – 1150*
Spec CPL	*609*	*0 – 200*

4. On October 11, 2017, Respondent went over the blood work. He noted the elevated WBC and felt that was expected given the severity of the dog's dental issues. Respondent did not relay the results to the pet owner or recommend antibiotics prior to anesthesia.

5. On October 12, 2017, Complainant stated that since she had not heard from Respondent regarding the blood work results she called the premise. She was advised from premise staff that Respondent said the blood work was perfect and to bring the dog in for the dental procedure the following day.

6. On October 13, 2017, the dog was presented to Respondent for a dental procedure. Staff noticed that IV fluids were not on the estimate; Complainant authorized the IV catheter and fluids. Complainant again asked if the blood work was satisfactory for the dog to receive general anesthesia and was again told the blood work was impeccable. Paperwork was signed and Complainant left the premise.

7. Upon exam, the dog had a weight = 3 pounds, 14 ounces, a temperature = 100.8 degrees, a heart rate = 124bpm and a respiration rate = 28rpm. The dog was administered atropine 0.135 mg with acepromazine 0.1mL/mg (?) SQ, induced with isoflurane and oxygen and an IV catheter was placed – Lactated Ringer's Solution was started (amount received unknown). Respondent began to elevate teeth and the dog went into cardiopulmonary arrest.

Resuscitation efforts were started with chest compressions. Two doses of epinephrine were administered IV, two minutes apart – 0.03mLs and 0.3mLs (concentration unknown). The dog did not respond and passed away. Respondent contacted Complainant to advise her of what transpired.

8. Complainant expressed concerns that the dog was anesthetized when there were abnormalities on the blood work indicating she had a weakened immune system.

COMMITTEE DISCUSSION:

The Committee discussed that it would have been prudent for Respondent to have discussed the blood work abnormalities with Complainant, especially the elevated WBC and abnormal pancreatic test. The kidney and liver values were fine, which process the anesthesia. The WBC clearly shows an infection was present however it would not cause the dog to arrest. The veterinarians on the Committee would have postponed the dental and prescribed antibiotics for a week prior to the procedure, and rechecked the SPEC CPL test but did not think it would have changed an anesthetic death.

The Committee discussed the amount of atropine and acepromazine administered to the dog were high and could have contributed to the death of the dog. The isoflurane induction also could have caused stress on the cardiac tissue. Atropine and acepromazine is not a current pre-medication but could be still acceptable.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to use current professional and scientific knowledge for using elevated doses of atropine and acepromazine.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

Tracy A. Riendeau, CVT
Investigative Division